THE LAW COMMISSION
AND
THE SCOTTISH LAW COMMISSION

CONSUMER INSURANCE LAW: PRE-CONTRACT DISCLOSURE AND MISREPRESENTATION

Joint Report

SUMMARY

1.1 The English and Scottish Law Commissions recommend new legislation covering the issue of what a consumer should tell an insurer before taking out insurance. The report includes a draft Bill to be laid before Parliament.

1.2 The current law requires a consumer to volunteer information about anything which a "prudent insurer" would consider relevant. This no longer corresponds to the realities of a modern mass consumer insurance market. Most consumers are unaware that they are under a duty to volunteer information. Even if they are aware of it, they usually have little idea of what an insurer might think relevant.

1.3 It is clearly important that insurers receive the information they need to assess risks. Most insurers, however, now accept that they should ask questions about the things they want to know. Our draft Bill replaces the duty to volunteer information with a duty on consumers to take reasonable care to answer the insurer's questions fully and accurately.

1.4 Where a consumer does make a mistake on an application form, the draft Bill distinguishes between mistakes which are "reasonable", "careless" or "deliberate or reckless":

(1) For *reasonable* misrepresentations, the insurer must pay the claim.

(2) For *careless* misrepresentations, the draft Bill provides a proportionate remedy, based on what the insurer would have done had it known the facts.

(3) For *deliberate or reckless* misrepresentations, the insurer may refuse the claim.

1.5 These ideas are not new. They reflect the approach already taken by the Financial Ombudsman Service (FOS) and generally accepted good practice within the industry. Our proposed reforms would, however, make the law simpler and clearer, allowing both insurer and insured to know their rights and obligations. Insurers would therefore be less likely to turn down claims unfairly, and consumers would have greater confidence in the insurance industry.

PROBLEMS WITH THE CURRENT LAW

1.6 The "duty of disclosure" was developed by judges in the eighteenth and nineteenth centuries and codified by Parliament in 1906. Although the 1906 Act is titled the "Marine Insurance Act", the courts have consistently held that it applies to all forms of insurance, including consumer insurance.

1.7 The report identifies four problems with the 1906 Act, which the draft Bill is designed to address:

(1) *The duty to disclose may operate as a trap for consumers*. Consumers are usually unaware that this duty exists or, even if they know that they should disclose facts, they may have no idea of what is relevant to the insurer.

(2) *Policyholders may be denied claims when they have acted honestly and reasonably*. If the untrue statement is deemed to be one of fact rather than belief, it does not matter that the consumer tried his or her best to get it right.

(3) *The remedy for misrepresentation and non-disclosure may be overly harsh*. The law entitles the insurer to "avoid" the policy. This means that the insurer may refuse all claims, even claims which the insurer would have paid had it been given full information. This is appropriate where consumers are deliberate or reckless, but not appropriate where they are merely careless.

(4) *A statement on a proposal form can be converted into a warranty using obscure words that most policyholders do not understand*. If a prospective policyholder signs a statement on the proposal form stating that the answers form "the basis of the contract", this converts all the answers into warranties. If any statement is incorrect, the insurer may refuse all claims, even if the mistake is of no importance to it.

CALLS FOR REFORM

1.8 There have been many previous calls for reform in this area: by the Law Reform Committee in 1957; the English Law Commission in 1980; and the National Consumer Council in 1997. In 2002, the British Insurance Law Association put forward strong arguments for change, and encouraged us to look at this area again.[1]

1.9 In 2006 the English and Scottish Law Commissions set up a joint review of insurance law. Our recommendations follow extensive consultation. In July 2007 we published a consultation paper,[2] and received over a hundred responses.

[1] For references to these reports, see Joint Report, paras 1.5 to 1.7.

[2] Insurance Contract law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.

1.10 The responses showed strong support for reforming consumer law, not only from consumer groups, brokers, lawyers and the FOS, but also from insurers themselves. As one reinsurer put it, reform would "enhance the reputation of the industry by reducing the scope for insurers to rely on strict legal rights that are unfairly balanced in their favour".[3]

1.11 We have therefore drafted consumer legislation as a priority. Our recommendations to change business insurance law will follow in 2010.

LAYERS OF RULES, GUIDANCE AND CODES

1.12 Despite the many calls for reform, there has been no legislative change. The insurance industry did not seek to justify the principles set out in the Marine Insurance Act 1906. Instead the Association of British Insurers (ABI) argued that problems with the law could be dealt with through "market-based solutions" rather than legislation.

1.13 The issue has been subject to overlapping and inconsistent layers of industry statements, FSA rules, ombudsman-discretion and codes of practice:

(1) *Statements of Practice* were issued in 1977 and strengthened in 1986. Insurers agreed not to rely on their strict legal rights in some circumstances.

(2) The *Financial Services Authority* (FSA) has incorporated some principles in the Statements of Practice into its rules. For example, the rules state that an insurer must not refuse to meet a claim on the ground of misrepresentation unless it was fraudulent or negligent.[4] The FSA rules do not amend the law. Instead, courts are required to apply the 1906 Act. In theory, an insurer could rely on its legal rights, win its case before a court, and then face the threat of an FSA fine.

(3) The *Financial Ombudsman Service* (FOS) has a statutory power to determine complaints according to what is "fair and reasonable in all the circumstances".[5] The FOS is not bound to decide cases according to the strict law. Instead it has developed its own approach, which goes further than the FSA rules. Where the insurer failed to ask about an issue, the FOS does not require consumers to volunteer information. Furthermore, where a consumer has answered a question carelessly, the FOS does not allow the insurer to avoid the policy. Instead, the FOS applies a compensatory remedy, based on what the insurer would have done had it known the truth.

[3] Scottish Re: see Joint Report, para 1.15.

[4] Investment Conduct of Business Sourcebook, Rule 7.3.6(2)(b).

[5] Financial Services and Markets Act 2000, s 228(2).

(4) In January 2008, the ABI issued formal Guidance on non-disclosure in long-term protection insurance.[6] This responded to public disquiet about refusal rates in critical illness insurance. The industry recognised that insurers should not necessarily refuse claims for careless errors. Instead, insurers should consider what they would have done had they known the full facts. The Guidance was upgraded to the status of a Code in January 2009.[7]

1.14 We welcome the 2008 Guidance (and its subsequent elevation to a Code). In 2006, concerns were expressed that over 10% of critical illness claims were refused for non-disclosure.[8] Since 2007, there has been a welcome reduction in the number of complaints about critical illness and income protection reaching the FOS.[9] However, problems about non-disclosure cover a wide range of insurance types. The ABI Code does not cover general insurance, such as household or vehicle insurance, and there is no evidence of a fall in complaints in these areas.

1.15 The different sets of rules have led to confusion. The FSA gives guidance suggesting that insurers should *either* ask clear questions *or* explain the duty to disclose material circumstances. The result is that insurers issue hundreds of warnings along the lines that "failure to disclose any material information may invalidate your insurance cover". Yet the FOS does not recognise a requirement to disclose material information: only to answer the questions asked.

1.16 We found several recent examples where insurers refused claims because the consumer failed to volunteer information, even though no question was asked. Some insurers simply fail to understand the FOS guidance on the subject.

> Mr and Mrs D insured their house and contents with a major insurer. They were sent a policy schedule giving the last renewal date as 15 January 2007. In July 2007, they made a claim for water damage.
>
> The insurer refused the claim because Mr D did not disclose that he was convicted of common assault on 1 June 2007. The insurer pointed to the key facts document which described the policy as "a monthly contract". The insurer argued that this put the consumer under a duty to disclose material facts on a monthly basis, even though no questions were asked.
>
> The ombudsman required the insurer to deal with the claim. She held that Mr and Mrs D had a duty to disclose the conviction only when the policy was due for renewal on 15 January 2008, and "then only in response to a clear question".

6 ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008).

7 See ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

8 London Economics estimated that out of 17,500 critical illness claims made, 11% were refused. Refusal rates ranged from 3% to 17%, depending on the insurer. See Consultation Paper, Appendix B.

9 In 2006-07, the FOS closed 376 complaints where non-disclosure was the dominant issue in critical illness and income protection disputes. In 2008-09, it closed 130 such cases.

1.17 The problem is that only a minority of consumers who experience problems complain to the FOS. Where an insurer refuses a claim in contravention of FOS guidelines, the consumer may not realise that the FOS will uphold the claim.

1.18 Furthermore, many insurers continue to state that answers on proposal forms "form the basis of the contract", even though, since 1986, insurers have agreed not to use such clauses.

THE NEED FOR LEGISLATION

1.19 Each year, around three-quarters of households buy insurance.[10] The question of what a consumer must tell an insurer before entering into the contract is one which concerns all consumers who take out insurance and all the insurers who deal with them.

1.20 We estimate that each year the issue generates around a thousand complaints to the FOS,[11] and an unknown number of disputes not taken to the FOS. These disputes often come at a particularly sensitive time. Many of the complainants in our surveys were seriously ill or recently bereaved. The disputes may also involve substantial claims: three out of the forty-seven recent cases we looked at involved more than £100,000.

1.21 The law in this area needs to be clear, straightforward and fair. The report identifies five problems with the current reliance on codes and guidance:

(1) *Consumers are only able to obtain justice from the FOS, not from the courts*. Although the FOS decides cases according to what is fair and reasonable, it cannot help all those with disputes. Where the amount in dispute exceeds the FOS's compulsory jurisdiction limit of £100,000, the FOS can only recommend that the insurer pays the full amount: it cannot require it. The following case, taken from our survey, outlines the problems. In this case, if the insurer refused to pay the balance over £100,000, the insurer would be forced to go to court, where the 1906 Act would apply.

> Mr C took out critical illness insurance for £119,000. The form asked a complex question about heart problems which included reference to "high blood pressure". Mr C said he had not had heart problems.
>
> When Mr C later suffered a heart attack, the insurers refused his claim. They discovered that his medical notes showed raised blood pressure readings 18 months previously. Mr C had not received any treatment for these, and they were not thought a cause for concern at the time.

[10] In 2007, 76% of households took out contents insurance, and 74% took out vehicle insurance. Just over a third had life insurance: Office for National Statistics, *Family Spending and Family Expenditure Survey* (September 2009).

[11] The last available figures, for 2006-07, show that the FOS closed 1,047 complaints from consumers about issues of non-disclosure and misrepresentation. In November 2009, we read a sample of ombudsman decisions, which led us to estimate that around 1,000 such cases were also closed from 2008-09.

The ombudsman found that the misrepresentation was innocent. She awarded Mr C £100,000. She also recommended that the insurer should pay the balance, commenting:

"*This recommendation is not part of my determination or award. It does not bind the business. If the business does not pay the recommended balance and Mr C decides to sue for the balance in court, the court would need to make its own decision on whether or not to award anything*."

(2) *The rules applying to non-disclosure and misrepresentation are unacceptably confusing*. Many of the "warnings" given by insurers on this subject are misleading rather than helpful. Claims handlers sometimes fail to understand what the FOS requires, leading to claims being rejected unfairly. Additionally, many consumers with rejected claims do not realise that they have a right to complain to the FOS. The resulting muddle leads to a loss of confidence in the insurance industry.

(3) *Confusion over the law penalises some vulnerable groups*. We have been told that particular problems exist for older consumers, for those with criminal convictions and for those with multiple sclerosis.

(4) *The present system imposes inappropriate roles on the FOS, the FSA and the courts*. The FOS is forced to act as a policy-maker rather than an adjudicator; the FSA is distracted from its key purpose; and the courts are systematically forced to reach unfair decisions.

(5) *Increasingly, differences in law between the UK and its European partners need to be justified*. The law as set out in the Marine Insurance Act 1906 and the various layers of rules and guidance cannot be justified before an international audience.

THE DRAFT BILL

1.22 The draft Bill is short and targeted. It applies only to consumer insurance contracts: that is, to insurance bought by individuals for purposes wholly or mainly unrelated to their trade, business or profession. Furthermore, it only deals with the issue of what a consumer must tell an insurer before entering into or varying an insurance contract.

1.23 The policy behind the draft Bill is summarised in Part 4 of the report and explained in detail in Parts 5 to 9. In Appendix A we set out each clause of the draft Bill together with explanatory notes.

THE CORE SCHEME

1.24 The draft Bill abolishes the duty currently imposed on consumers to volunteer material facts. Instead, consumers are required to take reasonable care not to make a misrepresentation. This new duty is central to the draft Bill. It means that consumers must take reasonable care to answer insurers' questions fully and accurately. If consumers do volunteer information, they must take reasonable care to ensure that the information is not misleading.

1.25 Where an insurer has been induced by a misrepresentation to enter into an insurance contract, the insurer's remedy will depend on the consumer's state of mind:

(1) Where a misrepresentation is *honest and reasonable*, the insurer must pay the claim. The applicant is expected to exercise the standard of care of a reasonable consumer, bearing in mind a range of factors, such as the type of policy and the clarity of the question. The test does not take into account the individual's own subjective circumstances (such as knowledge of English), unless these were, or ought to have been, known by the insurer.

(2) Where a misrepresentation is *careless*, the insurer has a compensatory remedy. This is based on what the insurer would have done had the consumer taken care to answer the question accurately and completely. For example, if the insurer would have added an exclusion, the insurer need not pay claims which fall within the exclusion but must pay all other claims. If the insurer would have charged more, it must pay a proportion of the claim.

(3) Where the misrepresentation is *deliberate or reckless*, the insurer may "avoid the policy". In other words, it may treat the policy as if it does not exist and decline all claims. The insurer would also be entitled to retain the premium, unless there was a good reason why the premium should be returned.

1.26 We have consulted widely on definitions of "reasonable" and "deliberate or reckless". We are encouraged that the ABI Code has largely adopted the definitions we proposed in our consultation paper.

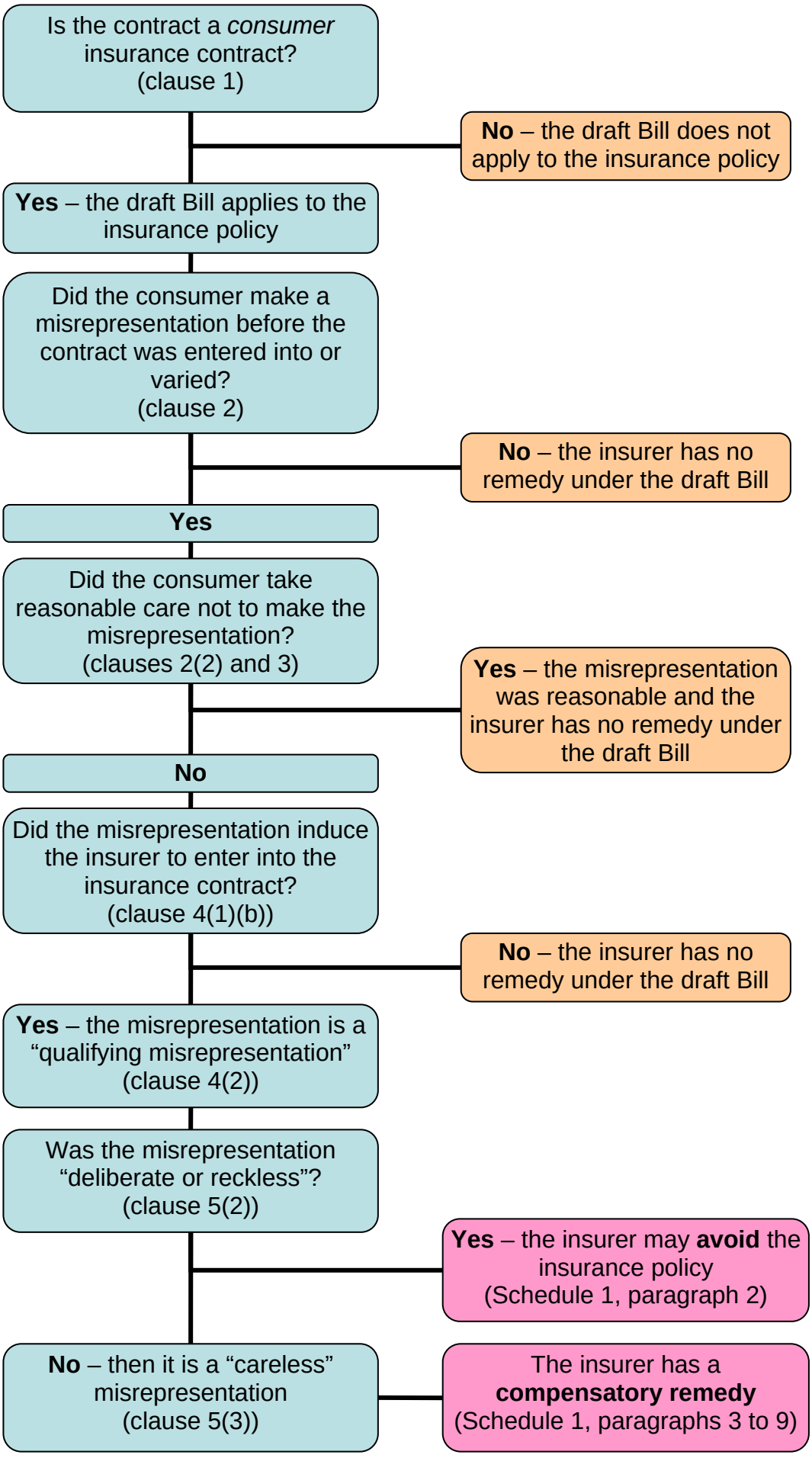
1.27 For a misrepresentation to be considered "deliberate or reckless" the insurer must show on the balance of probabilities that the consumer:

(1) knew that the statement was untrue or misleading, or did not care whether it was or not; and

(2) knew that the matter was relevant to the insurer, or did not care whether it was or not.

However, if a reasonable person would have known that the statement was untrue, the burden of proof would be on the consumer to show that he or she had less than normal knowledge. Similarly, if the question was clear, it would be up to the consumer to show why he or she did not think the matter was relevant.

1.28 The new scheme is best thought of as a series of questions which the insurer, court or ombudsman must ask before deciding to reject all or part of the claim. These are set out as a flow diagram overleaf.


Is the contract a *consumer* insurance contract? (clause 1)
No – the draft Bill does not apply to the insurance policy
Yes – the draft Bill applies to the insurance policy
Did the consumer make a misrepresentation before the contract was entered into or varied? (clause 2)
No – the insurer has no remedy under the draft Bill
Yes
Did the consumer take reasonable care not to make the misrepresentation? (clauses 2(2) and 3)
Yes – the misrepresentation was reasonable and the insurer has no remedy under the draft Bill
No
Did the misrepresentation induce the insurer to enter into the insurance contract? (clause 4(1)(b))
No – the insurer has no remedy under the draft Bill
Yes – the misrepresentation is a "qualifying misrepresentation" (clause 4(2))
Was the misrepresentation "deliberate or reckless"? (clause 5(2))
Yes – the insurer may **avoid** the insurance policy (Schedule 1, paragraph 2)
No – then it is a "careless" misrepresentation (clause 5(3))
The insurer has a **compensatory remedy** (Schedule 1, paragraphs 3 to 9)

INTERMEDIARIES

1.29 Insurance is often bought through intermediaries, who may use a variety of titles (such as “broker”, “agent” or “consultant”). It is not unusual for consumers to blame the intermediary for giving inaccurate or misleading information to insurers. An intermediary might, for example, give poor advice about what to include on a proposal form, or write down the consumer’s answers incorrectly.

1.30 In law, if an agent acts for the consumer, the consumer is held responsible for the agent’s actions. This means that if the consumer’s agent acted deliberately or recklessly then, under our recommended scheme, the insurer could avoid the claim. If the agent acted carelessly, a compensatory remedy would be applied. This is true even if the consumer had acted reasonably throughout the process. The consumer would then face the difficulty of bringing a claim against the intermediary.

1.31 On the other hand, if the intermediary acted as an agent for the insurer, the insurer would be required to pay the claim. It could then pursue its own remedy against the intermediary.

1.32 It is therefore important to know for whom an intermediary acts when helping a consumer complete an insurance application. Unfortunately, the law in this area is uncertain, as the courts and the FOS have struggled to apply early twentieth century cases to a rapidly changing market place.

1.33 This is a difficult issue, and we have amended our policy since publication of the consultation paper. We now recommend a statutory code, based largely on the existing law, as supplemented by FOS practice and industry understanding. Our aim is to give greater guidance, while retaining flexibility for the FOS and the courts to adapt to new arrangements.

1.34 The draft Bill states that an intermediary is considered to act for the insurer if:

(1) the intermediary is the appointed representative of the insurer;

(2) the insurer has given the intermediary express authority to collect the information as its agent; or

(3) the insurer has given the intermediary express authority to enter into the contract on the insurer’s behalf.

1.35 In other cases, the intermediary is presumed to act for the consumer unless it appears that it acts for the insurer. The issue would need to be determined by looking at all the circumstances. The draft Bill sets out a list of factors which may be relevant, but the courts and the FOS would be able to consider new factors as the market changes.

OTHER ISSUES

1.36 In addition, the draft Bill:

(1) Abolishes “basis of the contract” clauses.

(2) Makes special provisions for group schemes, where one party (typically an employer) arranges insurance to benefit members of the group (typically employees). The draft Bill brings the law into line with good practice by providing that where a group member makes a misrepresentation, it has consequences only for that individual, not for others within the group.

(3) Deals with situations where one consumer takes out insurance on the life of another. If the person whose life is insured makes a careless or deliberate misrepresentation, the insurer has a remedy.

(4) Prevents insurers from contracting out of the proposed scheme to the detriment of the consumer.

PROPOSALS NOT INCLUDED

1.37 Two proposals made in the consultation paper are not included.

Warranties

1.38 The draft Bill does not reform the law of warranties, except to abolish “basis of the contract” clauses. We have decided to postpone reform of consumer warranties and deal with them alongside the business reforms.

A five-year cut-off

1.39 The consultation paper asked whether in consumer life insurance, insurers should be prevented from relying on a negligent misrepresentation after the policy had been in force for five years. We accept that a five-year cut-off applying only to life insurance was an arbitrary measure, and not essential to the scheme. It does not form part of our current recommendations.